MaineCare

Value-Based Purchasing Strategy & CMMI State Innovation Model Grant

Appropriations

February 28, 2013
In August 2011, Maine DHHS announced Value-Based Purchasing Strategy

The Department moved away from a Managed Care philosophy focused principally on cost-containment to leverage on-the-ground initiatives to achieve the right care for the right cost.

Create Accountable Communities

Improve Transitions of Care

- ED Collaborative Care Management Initiative
- Health Homes focus

Strengthen Primary Care

- Maine PCMH Pilot/ Health Homes Initiative
- Reform of Primary Care Provider Incentive Payment program
Health Homes Initiative
CMS Health Homes – ACA Section 2703

- CMS will provide 90/10 match for Health Home services to eligible members for eight quarters
- CMS must approve Medicaid “State Plan Amendment”
- Health Homes may serve individuals with:
  - Two or more chronic conditions
  - One chronic condition and who are at risk for another
  - Serious mental illness
    - Adults with serious mental illness (SMI)
    - Children with severe emotional disturbance (SED)
- Dual eligible beneficiaries cannot be excluded from Health Home services
Required Health Home services include:

– Comprehensive care management
– Care coordination and health promotion
– Comprehensive transitional care from inpatient to other settings
– Individual and family support
– Referral to community and social support services
– Use of health information technology (HIT)
– Prevention and treatment of mental illness and substance abuse disorders
– Coordination of and access to preventive services, chronic disease management, and long-term care supports
Maine’s Medical Home Movement

~ 540 Maine Primary Care Practices (400+ PCCM providers)

~150+ MaineCare Health Home Practices

25 Maine PCMH Pilot Practices

50 PCMH Pilot Phase 2 Practices

14 FQHCs CMS Advanced Primary Care Demo

FQHC 37
Hospital-owned 97
Indep. 20
Total 154
Maine’s Health Homes Proposal

- Medical Homes
- Community Care Teams (CCTs)
- Health Homes
Chronic conditions

(perm CMS):
- Mental health
- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Overweight (BMI > 25) & Obesity

Maine-specific:
- Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Hyperlipidemia
- Tobacco use
- Developmental Disabilities & Autism Spectrum
- Acquired brain injury
- Cardiac & circulatory congenital abnormalities
- Seizure disorder
Maine Health Homes Proposal

Stage A:
- Health Home = Medical Home primary care practice + CCT
- Payment weighted toward medical home
- Eligible Members:
  » Two or more chronic conditions
  » One chronic condition and at risk for another

Stage B:
- Health Homes = CCT with behavioral health expertise + Medical Home primary care practice
- Payment weighted toward CCT
- Eligible Members:
  » Adults with Serious Mental Illness
  » Children with Serious Emotional Disturbance
Maine Health Homes Proposal

Stage A: Help Individuals with Chronic Conditions
Maine Health Homes Proposal

**Stage B:** Help Individuals with SPMI and/or SED
Maine Health Homes Timeline

- **2011-12**
  - Stakeholder engagement

- **Jul 2012**
  - 1st round Stage A Health Homes selection

- **Sep 2012**
  - Stage B-specific engagement begins

- **Oct 2012**
  - Stage A SPA submission

- **Dec 2012**
  - 2nd round Health Homes selection

- **Jan 2013**
  - Stage A implementation
  - Stage A SPA approval

- **Spring 2013**
  - Submit Stage B SPA

- **Fall 2013**
  - Implement Stage B
Emergency Department
Collaborative Care Management Initiative
ED Collaborative Care Management Project Objectives

• Reduce avoidable ED use and improve health outcomes for high needs, high utilizers of the ED through statewide care management effort:
  – Leveraging care management resources in the community.
  – Identifying and filling in the gaps where no care management capacity exists.
• Increase availability of ED for true emergency situations.
Development of ED Collaborative Care Management Project

• Based on successful pilot with MaineGeneral initiated in September, 2010, which achieved a 33% reduction in ED visits by MaineGeneral’s 35 highest ED users.

• Expanded statewide starting in summer 2011, holding kick-off meetings with Maine’s 36 hospitals over the summer and fall.
ED Collaborative Care Management Partnerships

- Hospitals
- Primary Care Provider (PCP) offices
- Behavioral Health Providers
- State Agencies
- Emergency Personnel
- Other existing care managers statewide to avoid duplicating efforts
- Patients
ED Care Management Process (in development)

1. **Identify Member**
   - MaineCare eligible?
     - Yes: Close case, inform hospital
     - No: Reach out to all providers and discuss ED use

2. **Discuss project, ED usage, ID barriers**
   - Has PCP?
     - Yes: Contact member
     - No: Send letter

3. **Establish PCP**
   - Contact member
     - Yes: Discuss project, ED usage, ID barriers
     - No: Send letter

4. **Meet with Hospital**
   - Yes: Discuss findings, Develop care plan, next steps
     - No: Community lead

5. **Community lead**
   - Yes: Community Care Manag?
     - Yes: MaineCare lead
     - No: Notify all providers of plan

6. **Monthly meetings w hospital to monitor, update plan**
   - No ED visits >4 months?
     - Yes: Close case, but monitor.
     - No: Troubleshoot with providers
       - 1st try
       - 2nd try: Community mtg w all providers

7. **Has PCP?**
   - Yes: Establish PCP
     - No: Contact member

8. **MaineCare lead**
   - Yes: Community Care Manag?
     - Yes: MaineCare lead
     - No: Notify all providers of plan

9. **Referrals to specialists, behav. health**
   - Yes: Med management
     - No: Notify all providers of plan
ED Collaborative Care Management Project Success

• Currently serves almost 1000 high utilizing MaineCare members through collaboration with 36 hospitals. Over 1600 members have been served since inception of the Initiative

• Connecting Primary Care and Behavioral Health providers

• Consistent message to the member from all existing providers

• Saved over $6M in FY12 compared to FY11. An additional $3.75M is projected in FY13.
Accountable Communities Initiative
Accountable Communities: What is an Accountable Care Organization (ACO)?

The definition of an ACO depends on who you ask...

The Department is adopting the simple definition that an ACO is:

An entity responsible for population’s health and health costs that is:

• Provider-owned and driven
• A structure with a strong consumer component and community collaboration
• Includes shared accountability for both cost and quality
MaineCare Accountable Communities

**Basic Components:**

- Providers will be able to come together to engage in an alternative contract with the Department to share in any savings achieved for an assigned population.
- The amount of shared savings will depend on the attainment of quality benchmarks.
- Open to any willing and qualified providers statewide.
  - Qualified providers will be determined through an application process.
  - Accountable Communities will not be limited by geographical area.
- All fully eligible Medicaid members eligible, including duals.
- Members retain choice of providers.
- Alignment with aspects of other emerging ACOs in the state wherever feasible and appropriate.
- Flexibility of design to encourage innovation.
Accountable Communities: Will start with a shared savings model

- Savings accrued to state
- Savings accrued to ACO
- Will be based on risk-adjusted actuarial analysis of projected costs.
The Department has proposed that the Accountable Communities Initiative feature two models:

1. Shared Savings Only: minimum 1000 patients attributed
   - Share in a maximum of 50% of savings, based on quality performance
   - Are not accountable for any downside risk in any of the three performance years
   - Subject to lower per patient cap

2. Shared Savings & Losses: minimum 2000 patients attributed
   - Share in a maximum of 60% of savings, based on quality performance
   - Are not accountable for any downside risk in the first performance year
   - In year 2, are accountable for up to 5% of any losses.
   - In year 3, are accountable for up to 10% of any losses.
   - Must demonstrate capacity for risk sharing
Accountable Community Eligibility Requirements

Accountable Communities must:

• Be assigned a minimum number of MaineCare members, to be determined
• Include MaineCare-enrolled providers
• Deliver primary care services
• Directly deliver or commit to coordinate with specialty providers, including behavioral health for non-integrated practices, and all hospitals in the proposed service area.
• Commit to:
  – Integration of behavioral and physical health
  – Demonstrated leadership for practice and system transformation
  – Inclusion of patients & families as partners in care, and in organizational quality improvement activities and leadership roles
  – Developing formal and informal partnerships with community organizations, social service agencies, local government, etc. under the care delivery model
  – Participation in Accountable Community and/or ACO learning collaborative opportunities
Accountable Communities “Core” Services Recommendations

Services, not members or providers, may be excluded from the total cost of care for which the Accountable Communities is responsible. All medical costs for these members would still be included.

Accountable Communities must include all “core” services. Accountable Communities may choose to include services listed as optional.

Core:
» Inpatient
» Outpatient
» Emergency Department
» Physician
» Pharmacy
» Mental Health
» Substance Abuse
» Hospice
» Home Health
» School-based primary care
» School-based day treatment

Optional:
» Waiver
» Nursing Facilities (except physical, occupational and speech therapy that occurs at the facilities)
» Private Duty Nursing Services
» Dental

Excluded:
» Transportation
» Private Non-Medical Institutions (PNMIs)
» School-based rehabilitation
Accountable Communities Timeline

Spring 2012
• Actuarial analysis initiated (ongoing)

8/2012
• Discussions initiated with CMS regarding SPA development and submission (ongoing)

Spring 2013
• Issue Accountable Communities application

Summer 2013
• Submission of SPA
• Accountable Communities selected

Fall 2013
• Accountable Communities Implementation
Center for Medicare and Medicaid Innovation (CMMI) State Innovation Model (SIM) Grant
CMMI State Innovation Models

“...to test whether new payment and service delivery models will produce superior results when implemented in the context of a state-sponsored State Health Care Innovation Plan. These plans must improve health, improve health care, and lower costs for a state’s citizens through a sustainable model of multi-payer payment and delivery reform, and must be dedicated to delivering the right care at the right time in the right setting.”

- **Goal**: lower costs for Medicare, Medicaid, and CHIP
- **Rationale**: Governor-sponsored, multi-payer models.. set in the context of broader state innovation → sustainable delivery system transformation
- **Emphasis**: in addition to ACOs and medical homes, should include community-based interventions to improve population health, with a focus on behavioral health
Grant Overview

- Maine was one of only six states to receive a combined total of over $250 million to implement their State Health Care Innovation Plans, designed to use all of the levers available to them to transform the health care delivery system through multi-payer payment reform and other state-led initiatives.

- **Maine’s Grant amount**: $33 million
- **Grant timeline**: 6 months of pre-implementation beginning April 1, followed by a 3-year testing period
- **Grant recipients**: The Governor’s Office, in partnership with Maine DHHS and MaineCare
- **Grant partners**: Maine Health Management Coalition, HealthInfoNet, Maine Quality Counts
Leverage the state’s investment in the Maine multi-payer Patient Centered Medical Home Pilot and MaineCare Health Homes Initiatives to form multi-payer Accountable Care Organizations that commit to:

- Tying payment to achievement of cost and quality benchmarks
- Public reporting of common quality benchmarks
The SIM Project builds off the very strong work in Value-based Purchasing under MaineCare and across the State’s private sector.

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<th>Engaged Communities</th>
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<tr>
<td>• Public Health</td>
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<td>• Community Paramedicine</td>
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<td>• Universities/ Community Colleges</td>
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<th>Accountable Care Organizations</th>
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<td>• Providers accountable for cost and quality of assigned population</td>
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<td>• Transition to greater accountability over time</td>
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<td>• Care Coordination</td>
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<td>• Social and Community Support</td>
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<td>• Clinical/Claims Data for Population Health Management</td>
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<td>• Integrated Behavioral Health</td>
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<td>• Shared Decision Making</td>
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How will patients benefit?

• All patients will benefit from primary care practices where:
  – The wait for appointments is shorter
  – It’s easier to get seen for urgent care
  – Doctors and other medical staff coordinate with other medical providers to make sure everyone is on the same page regarding diagnoses, prescriptions, and treatment plans.

• Tools to help them better manage their own health.

• Connections with community resources, such as heating and housing assistance

• Community health workers will help them navigate the healthcare system and create their own paths to improved health.

• Adults and children with developmental disabilities and autism spectrum disorders will benefit from practices and doctors that have been trained to better meet their needs.

• Patients receiving community behavioral health services will benefit from direct service workers who understand the importance of assuring both physical and behavioral health needs are taken into consideration.
How will providers benefit?

• Payment reform will enable providers to spend more time with patients and focus on providing quality, coordinated care. Reforms may include:
  – Shared savings, based on performance
  – Share financial risk with employers based on their ability to meet cost and quality goals.
  – Monthly payments to support patient-centered care practices that are not reimbursable through traditional fee for service payment.

• Greater consistency across payers in terms reporting requirements and payment changes. Providers can then focus on care for all patients regardless of payer.

• Behavioral health providers will have access to share, where appropriate, both behavioral and physical health information through electronic health records.

• Care management staff will receive real-time notification for when their highest-utilizing patients use the ED or are admitted to or discharged from the hospital.

• Providers will learn from each other and from national experts on how to best coordinate and provide high quality, lower cost care for all patients, including those with serious mental illness.
How will the SIM project achieve cost containment and quality goals?

• Leverages purchasing power of the larger health care market. It aligns goals, measures, and payment and delivery reform across Medicare, Medicaid, and private purchasers.

• Provides us with statewide analysis of all payers that will allow us to see how a change in one area of the system impacts the system as a whole.

• Enhance the patient experience and brings a level of accountability across the system.

• Moves more and more payers and employers toward the connection between payment and accountability for cost and quality outcomes, which will result in better care for less cost for all patients, regardless of their insurance.
Maine is viewed nationally as a leader in the Value-Based Purchasing movement

- Selected to collaborate with CMS and other states to inform federal guidance on supporting value-based purchasing efforts under fee for service systems.
- One of only seven states to have made substantial progress toward implementing a Medicaid ACO.
- Achieved approval of Health Homes State Plan Amendment under fastest timeline of any state in the country.
- One of only six states to receive a SIM grant to test out strategies to achieve multi-payer system reform.
What would the introduction of a Managed Care approach to Maine Medicaid mean at this time?

• MCO’s are designed to manage care through separate administrative entities, VBP is designed for providers to better manage care
• VBP incents system transformation toward population health and away from FFS models
• VBP has a focus on outcomes as a central tenant of the model, while MCO’s are principally focused on cost
• VBP supports a shift toward an integrated care infrastructure which has been shown to benefit patient outcomes, while MCO’s reinforce the existing models of care
• Potential duplication of efforts
  – Maine’s VBP efforts and the SIM grant have and will continue to heavily invest in provider-based care management. MCOs have traditionally had their own care management strategies
  – The SIM grant invest heavily in multi-payer, system wide data analytics.
  – MCOs often bring in their own claims management systems
• Resource constraints, focus
  – Significant staff resources to implement managed care, SIM and VBP